

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155076</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>10/01/2013</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER- BROOKVIEW</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>7145 E 21ST ST</b> <b>INDIANAPOLIS, IN 46219</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00135117 and IN00135358.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00131572 completed 07/24/2013.</p> <p>Complaints IN00135117-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaints IN00135358-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: September 27, 30, 2013 and October 1 2013</p> <p>Facility number 000031 Provider number 155076 AIM number 100266150</p> <p>Survey team: Chuck Stevenson, RN,TC</p> <p>Census bed type: SNF/NF: 113 Total: 113</p> <p>Census payor type: Medicare: 9 Medicaid: 86 Other: 18 Total: 113</p> <p>Sample: 6</p> <p>Golden Living Center Brookview was found to be</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 in compliance with 42 CFR part 483, subpart B and 410 IAC 16.2 in regard to the Investigation of Complaints IN00135117 and IN00135358.  Quality review completed on October 18, 2013, by Janelyn Kulik, RN.	F 000			